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Harm Reduction News

Newsletter Focus

HIV Looming in Central Asia

by Kasia Malinowska-Sempruch

Central Asia is perfectly placed for a mega HIV epidemic. Drugs are produced, trafficked, and used throughout the region. People are impoverished and the economy is in shambles. Governments are weak. Compared to other countries in Central and Eastern Europe and the former Soviet Union, the history of communism in some parts of Central Asia left a more scarring legacy of repression. Women are subordinated. And the first instinct of any conservative culture seems to be to deny drug and sex issues, even when they are a public health concern.

We know what doesn't work. Seizing heroin at the border and putting drug users in prison doesn't stop HIV. And repressing the distribution of health information, as Chinese authorities recently did with AIDS activist Wan Yanhai, M.D., doesn't stop AIDS. Wan was detained just outside the Central Asian border for posting information about the contaminated blood supply in Henan province on the web. Wan had been selected in early July to be the first recipient of a joint award from Human Rights Watch and Canadian HIV/AIDS Legal Network International.

We know what works: harm reduction. Harm reduction interventions have a heartening chance to work in Central Asia because the epidemic is in the early stages. However, if harm reduction methods are going to be accepted in the region the climate must change. Governments must acknowledge widespread drug use; recognize drug users are an integral part of society—not isolated and expendable as many pretend; provide services for drug users; and assure their access is not prevented by legal repression or social stigma. When service providers and governments embrace these changes great things happen, as in Kyrgyzstan where people can now get methadone and stabilize their lives.

We dedicate this issue of *Harm Reduction News* to Central Asia and the complexities of its HIV epidemic. Several articles lay out the problems. The correlation between drug availability and trafficking with drug use and HIV is conclusively demonstrated by Chris Beyrer and his research. Jay Dobkin talks about the challenges of treating HIV patients in Central Asia. And all of the human rights fault lines, from international treaties to the right to exchange a needle without fear, are described in articles by Erika Dailey and Joanne Csete.

The devastation of Central Asia by HIV is not inevitable, but we must act quickly to change old, destructive patterns of behavior and clear the way for effective prevention.

The projects are the solution. Turkmenistan now offers harm reduction information and condoms to prisoners, one of the most vulnerable populations. Another vulnerable population, commercial sex workers, benefits from services in Uzbekistan. The youth of Central Asia are being trained to talk to disaffected street youth who are in danger of getting HIV. Given an opportunity through study tours to see harm reduction working, even police will come around to accept it. Tajikistan is trying to reach out to ever more drug users with its needle exchange projects, and Kyrgyzstan will soon evaluate the success of its pilot methadone projects, the first in Central Asia. And in an effort to better meet the HIV prevention needs of the region, a joint project of the U.S. Agency for International Development and the Open Society Institute is rapidly increasing the number of such projects in the region.

The devastation of Central Asia by HIV is not inevitable, but we must act quickly to change old, destructive patterns of behavior and clear the way for effective prevention.

HIV infection and heroin trafficking...page 4.

Inside

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IHRD Mission & Core Activities

The International Harm Reduction Development program (IHRD) supports local, national, and regional initiatives in Central and Eastern Europe, the Russian Federation, and Central Asia that address drug problems through innovative measures based on the philosophy of harm reduction. Harm reduction is a pragmatic and humanistic approach to diminishing the individual and social harms associated with drug use—especially the risk of HIV infection. The approach places an emphasis on human rights, common sense, and public health. In practice, harm reduction encompasses a wide range of drug user services including needle and syringe exchange, methadone treatment, health education, medical referrals, and support services.

IHRD reduces drug related harm by:

Providing grants and technical support to local direct service providers. IHRD supports over 180 harm reduction projects in more than twenty countries of Eastern Europe and the former Soviet Union. While all interventions are tailored to local conditions and client needs, the majority of projects include a needle exchange component. Making clean needles available to injection drug users has proven effective as an HIV prevention strategy.

Supporting regional, population-based, and topic-specific initiatives. IHRD supports regional conferences, trainings, and projects on issues such as street kids, HIV prevention in prisons, ethnic minorities (such as Roma communities), methadone treatment, and commercial sex workers.

Promoting local and regional capacity-building. IHRD builds capacity by funding and organizing trainings, workshops, and conferences for a variety of harm reduction stakeholders including NGO staff, government officials, policy officers, prison workers, and health care providers.

Creating an enabling public policy atmosphere. IHRD works to influence national-level drug policies and practices by sponsoring advocacy efforts, research, conferences, and decision-maker study tours.

IHRD is part of OSI's Network Public Health Programs and works in close cooperation with the local Soros Foundation Network and the Drug Policy Alliance.

OSI Mission

THE OPEN SOCIETY INSTITUTE is a private operating and grant-making foundation that seeks to promote the development and maintenance of open societies around the world by supporting a range of programs in the areas of educational, social, and legal reform, and by encouraging alternative approaches to complex and often controversial issues. The Open Society Institute is part of the Soros foundation network, an informal network of organizations created by George Soros that operate in over 50 countries around the world, principally in Central and Eastern Europe and the former Soviet Union, as well as in Guatemala, Haiti, Mongolia, Southern Africa, and the United States.

A Window of Opportunity to Control HIV

by Jennifer Adams and Valeria Gourevich

The growth of HIV in Central Asia is related to the serious socio-economic, political, and psychological problems prevalent in the region since independence in 1991. The dramatic increase in narcotics trafficking from Afghanistan through the region has accelerated drug use and concomitant HIV infection. Areas renowned in the past for their beauty and utility, such as the "road of life" from Osh to Khorog, which 25 years ago allowed for the transportation of food and other goods to the remote Pamirs, is now called "the road of death."

Poor legislative control, breaches in border and customs regulations, and widespread corruption among officials create a favorable environment for narcotics trafficking. In turn, the Central Asian countries through which drugs are transported on their way to more lucrative markets find a rapidly growing pop-ulation of at-risk groups. As the pace of HIV transmission increases in Central Asia, a pattern similar to some of the worst affected countries in the world is developing.

The Centers for Disease Control and Prevention, USA, has constructed simple projections for HIV trends in Central Asia. They estimate that without immediate, widespread, and effective prevention strategies, the HIV/AIDS infection rate may reach 3 percent by the end of 2005. HIV infections increased by 7 percent in Kazakhstan during the first five months of 2002, implying that by 2005 450,000 people could be infected with HIV.

Central Asia has a window of opportunity to contain the current relatively low rate of HIV transmission. But ineffective and limited prevention measures that are aimed at punishing those with HIV, chiefly injection drug users (IDUs), may prematurely shut that window.

Earlier this year, the Open Society Institute (OSI) and the Central Asia Regional Mission of the U.S. Agency for International Development (USAID) launched a joint prevention program that aims to cover the five Central Asian countries with effective HIV prevention interventions. A secretariat established under the umbrella of the Soros Foundation in Kazakhstan coordinates the activities. The OSI-USAID partnership is unique, as it also includes the Soros Foundation of Kazakhstan, the national Soros Foundations of Kyrgyzstan, Uzbekistan, and Tajikistan, and the United Nations Development Program representative in Turkmenistan.

Map of the Joint USAID-Soros Network Project, HIV Prevention in Central Asia.

The joint effort is already scaling up effective HIV prevention interventions among groups at risk—IDUs, commercial sex workers (CSWs), and prisoners. Before the partnership, OSI had implemented 18 harm reduction projects in Central Asia and now, with support from USAID and other partners, the total number of interventions should reach 34-38 by the end of 2003.

In Kazakhstan, sites were carefully selected for new programs in Astana, Pavlodar, Shimkent, and Temirtau. Astana is Kazakhstan's new capitol, where migration has caused a sharp increase in IDUs. In Temirtau, the epicenter of the Central Asian epidemic, the project will reach more than 1,000 IDUs and involve those already infected with HIV. In Pavlodar, a model site serving IDUs and CSWs will be developed. In Shimkent, located on the main drug trafficking route on the border with Uzbekistan, the number of CSWs who stand "on duty" near the highway will be the focus of a new project. In Tajikistan, the main transit point for drugs through Central Asia, four new projects will complement the two existing needle exchange programs. The experiences and lessons learned from work in these countries will inform the activities planned for Uzbekistan and Turkmenistan, where seven more projects will be launched this year, including pioneering work in prisons.

Central Asia needs the development of HIV prevention programs that promote open society principles and address the needs of vulnerable groups. These programs can help prop open the window of opportunity and maintain hope for controlling HIV infection in the region.

Jennifer Adams is the director of the Office of Social Transition, USAID Regional Office for Central Asia. Valeria Gourevich is the director of the Secretariat of the Joint USAID-Soros Network Project, HIV Prevention in Central Asia.

HIV Infection and Heroin Trafficking

by Chris Beyrer

The complex relationship between the epidemic spread of HIV and heroin trafficking is becoming increasingly clear. This emerging pattern can be seen along trafficking routes from the two primary illicit opium poppy growing and heroin manufacturing regions of the world: the Golden Triangle of Southeast Asia and the Golden Crescent of Central Asia. The data on the relationship between heroin trafficking and HIV are compelling. But at least two crucial questions still stand. Why have societies from Ukraine to Vietnam been so vulnerable to these interactions? And what can be done to reduce the growing harm?

The mechanisms that turn poppy cultivation into HIV outbreaks are just beginning to be understood, as is the special vulnerability of individuals and communities in trafficking zones. The main heroin producers for the Golden Triangle are Burma and Laos. For the Golden Crescent, Afghanistan and Pakistan. Currently, these states are thought to account for 80 to 90 percent of the world's heroin supply. In the Golden Triangle, the spread of HIV has been well documented in Burma, Thailand, China, India, Malaysia, Vietnam, and, more recently, Indonesia. For the Golden Crescent, where we have much less data and where the HIV epidemics are newer, the spread of HIV and/or hepatitis C appears to be underway in Pakistan, India, Iran, Tajikistan, Uzbekistan, Russia, Ukraine, Belarus, and several states in Eastern Europe.

Most studies in these regions investigating the spread of HIV in injection drug users (IDUs) have found that hepatitis C (HCV) infection is more common and may indicate vulnerability to future HIV spread. HCV prevalence among IDUs generally reaches 90 percent prevalence or higher soon after the introduction of the virus into IDU networks—a function of the very high transmissibility of the virus through injection.

Legal opium poppy cultivation for production of pharmaceutical drugs like morphine, codeine, and Demerol, is centered in Tasmania, Australia, India, and Turkey, and has not been associated with heroin production, trafficking, or the spread of blood borne infections. The links between heroin and HIV spread are due to the illicit nature of criminal production and distribution, increasing numbers of young users injecting with unsafe equipment, and a lack of HIV prevention services for drug users.

HIV Spread and Injection Drug Use

In 2000, our international team published the findings of investigations that used molecular epidemiology, satellite technology, qualitative research methods, and epidemiologic reviews of HIV infections along four heroin trafficking routes out of Burma and Laos and into China, India, Vietnam, and Thailand. Using DNA fingerprinting technology, we were able to show that HIV viruses from the blood of infected IDUs could help trace heroin routes. Further, heroin users and petty traders helped us to understand how heroin use spreads in communities and pointed to key roads, villages, towns, and cities through which Golden Triangle heroin was moving and leaving legacies of addiction and AIDS. Since our findings were published other groups have independently investigated these zones, confirming our findings and, sadly, documenting further spread and worsening health in communities in China, Vietnam, and Burma.

Likewise, the Crescent destination markets of Russia, Ukraine, Belarus, Kazakhstan, Pakistan, and Iran are all experiencing heroin use outbreaks among their young people, and all now appear to have HIV outbreaks or emerging epidemics related to this use. Heroin exports from Afghanistan and Pakistan are at the root of these complex new problems. The challenges are regional but point to a global problem which ties the Crescent to the Triangle: illicit heroin revenues.

On paper, Afghanistan was the world's poorest state in 2000, while Burma was one of the United Nations' "least developed" countries. Afghanistan is almost entirely dependent on donor aid in 2002 and has essentially no foreign reserves, a bankrupt treasury, and limited licit exports. We do not know the details of the economics of the trafficking networks based in the Golden Crescent, but we do know that taxes on poppy farmers and protection money from traffickers were among the main sources of revenue for both the Taliban and the Northern Alliance before the current regime came to power. In both Burma and Afghanistan, heroin has allowed for black market weaponspurchases to fund militias, insurgencies, and crime. Afghanistan has the potential to grow other crops, including grain and orchard production, but these require irrigation systems, which have largely been destroyed, and access to markets, which remains a huge challenge for much of the country.

Reducing the opium supply from these regions will require establishing viable alternative economies for the rural poor, which will take time, sustained donor investment, and stable functioning civil societies.

Legal opium poppy cultivation for production of pharmaceutical drugs has not been associated with heroin production, trafficking, or the spread of blood borne infections. Illicit criminal production and distribution has.

Tajikistan authorities burn bags of seized heroin and opium. Photo © 2002 Hans-Jürgen Burkard

Should Afghanistan descend again into civil strife and warlordism, heroin production will likely rise again. Indeed, as in Burma, it is in the interest of the narcotics cartels and the corrupt leaders they have often supported that civil society fail—a chilling reality given the wealth, power, and weapons that heroin revenues have already generated.

Another interaction may have special impact on both narcotics and HIV spread, though the data are limited. Along at least some of the major trafficking routes, overland trucking routes have led to the development of services for truckers. In addition to fuel, food, and lodging, these often include sex services. In Southeast Asia these sex services are generally roadside brothels, karaoke parlors, and bars. In Central Asia they may be less apparent and less understood but they are still available. In some settings sex services may have young male sex workers, as in the Pakistani trucking industry. These border zone sex service venues can overlap with drug trafficking and provide another mechanism for the spread of HIV. On the Burma-Thai and Burma-China borders, women and girls are trafficked on the same routes and by some of the same trafficking networks as heroin.

Policy Responses

Why have outbreaks of injection drug use associated with heroin trafficking proven so difficult to prevent or control? In the major production zones and their affected regions, treatment and prevention programs for drug users have been limited. In all of Asia the only place where heroin treatment and methadone maintenance are available on demand is in Hong Kong. This is tragic, given that there is clear and growing international evidence of harm reduction's success in preventing HIV infection and other blood-borne diseases among IDUs.

It is difficult to imagine public health tools with reasonable evidence of efficacy which have generated as much debate and remained as underused as HIV prevention programs for IDUs. A review of the literature suggests three principal problems with the implementation of harm reduction. First, it is repeatedly seen as condoning or facilitating injection drug use, making it politically unpopular. Second, it has faced legal, security, and policy challenges since it requires "safe" domains of interaction with active IDUs, a special concern in trafficking zones where criminal control may be extensive. And third, in order to effectively reach the IDU populations and stop the HIV epidemic, many more needle exchange programs must be available and used by IDUs.

Conclusions

Individuals, communities, and countries located on major heroin trafficking routes face multiple epidemics in 2002: heroin use, heroin injection, and the HIV infection that follows. While a clear long-term goal for these states is to be free of drug trafficking, the realities of the current political and development situations of the major producers, notably Burma and Afghanistan, suggest that narcotics-based economies will be with the world for some time. The health impacts of heroin trafficking could be minimized by a public health approach that includes reducing heroin addiction through improved treatment and support

continued on page 6

continued from page 5

for IDUs and reducing HIV spread through expanding harm reduction and needle exchange programs. Preventing the spread of HIV beyond IDUs may be critically important to the prevention of wider epidemics of HIV/AIDS.

Photo © 2002 Hans-Jürgen Burkard

It is difficult to imagine proven, effective public health tools which have generated as much debate andremained as underused as HIV prevention programs for IDUs.

A clear priority for further research and programs are the frontline Central Asian states in the Golden Crescent. These must be considered high risk states for the explosive spread of HIV in the coming years, and could benefit from the programmatic experience and research examining the heroin and HIV interactions of the Golden Triangle.

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References

Beyrer C., Razak M.H., Lisam K., Wei L., Chen J., Yu X.F. "Overland heroin trafficking routes and HIV-1 spread in South and Southeast Asia." *AIDS*, 2000; 14.

U.S. Department of State, Bureau of International Narcotics and Law Enforcement Affairs. *International Narcotics Control Strategy Report*, March 2002. Washington, DC.

Kato K., Shiino T., Kusagawa S., et al. "Genetic similarity of HIV type 1 subtype E in a recent outbreak among injecting drug users in northern Vietnam to strains in Guangxi Province of southern China." *AIDS Res Hum Retroviruses*, 1999; 15(13).

Piyasirisilp S., McCutchan F.E., Carr J.K., Sanders-Buell E., Liu W., Chen J., Wagner R., Wolf H., Shao Y., Lai S., Beyrer C., Yu, X.F. "A recent outbreak of HIV-1 infection in southern China was initiated by two highly homogeneous, geographically separated strains, circulating recombinant form AE and a novel BC recombinant." *J. Virol*, 2000; 74(23).

MAP (Monitoring the AIDS Pandemic.) "The Status and Trends of HIV/AIDS/STI epidemics in Asia and the Pacific." *Report Presented at the 6th International National Congress on AIDS in Asia and the Pacific*, Melbourne, Australia, Oct. 4, 2001.

Crofts N., Reid G., Deany P. "Injecting drug use and HIV infection in Asia." The Asian Harm Reduction Network. *AIDS*, 1998; 12 Suppl. B.

Bobkov A., Kazennova E., Selimova L., et al. "A sudden epidemic of HIV type 1 among injecting drug users in the former Soviet Union: identification of subtype A, subtype B, and novel gagA/envB recombinants." *AIDS Res Hum Retroviruses,* 1998; 14(8).

Rhodes T., Ball A., Stimson G.V., et al. "HIV infection associated with drug injecting in the Newly Independent States, Eastern Europe: the social and economic context of epidemics." *Addiction*, 1999; 94(9).

Beyrer C., "Shan Women and Girls and the Sex Industry in Southeast Asia: Political Causes and Human Rights Implications." *Soc. Sci. & Med.*, 2001; 53.

Sorensen J.L., Copeland A.L. "Drug abuse treatment as an HIV prevention strategy: a review." *Drug Alcohol Depend.*, 2000;59(1).

Subtyping HIV Strains

Molecular work in Central Asia is urgently needed to understand what viruses are spreading there and to help understand the movement of heroin in the region. This work is underway in a few states, and data may be available in the next year. HIV subtypes, in addition to their use in tracking spread, may have important implications for HIV vaccine research, and so this is not simply an academic question, but a public health one.

Molecular subtyping of HIV-1 strains has helped us to understand HIV spread in many settings. HIV-1 has numerous subtypes based on genetic differences, and are labeled HIV-1 subtype A, B, C, and so forth to K. There are also a number of new recombinant subtypes, generally named after their parent strains, such as the B/C recombinant found in China. In the trafficking zones around Burma subtypes B, C, E, and two different B/C recombinants have been found, and the patterns of their spread have helped describe both HIV dynamics and heroin trafficking.

In Central Asia virtually no subtyping data is available. So we do not know what HIV strains, if any, are circulating among IDUs in Afghanistan itself, Pakistan, Iran, or the republics.

Street Youth Get Help from Peers

by David James-Wilson with Lena Vinogradova

Marat is 14 years old and lives in a crumbling apartment complex built in the 1960s for workers at a now derelict shoe factory in Temirtau, Kazakhstan. His father is unemployed, depressed, and away from home for days at a time. His mother works for the city shoveling snow in the winter and sweeping streets in the summer. Openly shooting heroin in the toilets and sniffing solvents to ward off hunger, Marat's schoolmates go through the motions of studying in their overcrowded and underheated classes. Marat, who tries to make money from stolen windshield wiper blades, has been beaten up by police, offered money for sex by a local truck driver, and spends the little he earns to buy food for his sisters and cheap vodka to dull the pain of his nowhere life.

Marat is part of a swiftly growing population of street-involved youth in Central Asia. He is not yet homeless nor ready to abandon school entirely, but his life revolves more around making money and getting high than spending time in school or at his barely functioning neighborhood recreation center. He is at high risk for drug abuse and HIV, and is seen as a public nuisance and potential threat.

Young people like Marat need to discuss decisions about the risks they face with compassionate listeners. The best people to reach out to such youth are youth themselves.

Street Kids International (SKI) is working to bolster the skills of youth workers in Central Asia. Its first series of pilot Street Choices workshops for youth serving professionals in Kazakhstan, Kyrgyzstan, and Tajikistan was in 1999 and focused on drug use and HIV prevention. Local groups had grown tired of hosting international "experts" who advised them on how to transform their professional practice. By contrast, SKI brought the approach it developed with partners in South East Asia, Latin America, and Southern Africa that taps into local knowledge and approaches while also introducing new tools from colleagues in other countries.

The fundamental principles of SKI's workshop are *share, explore, practice,* and *contribute*. Best practices are shared; local conditions are explored; the integration of new tools with existing materials and methodologies is practiced; and local groups contribute their knowledge back to SKI's global program. The workshop itself reflects an open, responsive approach that SKI and its partners believe is best for street involved youth. Too often, youth are lectured at by "experts" who make little effort to understand the complex environments in which they live.

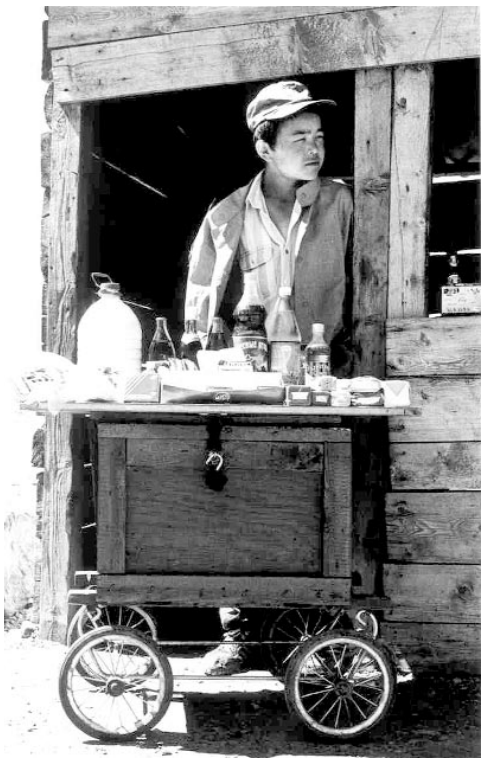


Photo © 2002 OSI-Kazakhstan

Youth programs must meet street youth on their own terms—without lectures, moralizing, or prescriptive solutions.

Central Asian workshop participants concluded that programs for street-involved youth need to go beyond providing information and warnings about the risk of drug use, needle sharing, or unprotected sex to develop young people's decision-making and health-promotion skills. They must meet street-involved youth on their own terms—without lectures, moralizing, or prescriptive solutions—and focus on harm reduction, self-care strategies, and genuine alternatives. Outreach workers must be equipped with holistic tools and methodologies to build open-ended relationships with marginalized youth, many of whom distrust the advice and guidance of adults on any subject, let alone drugs and sex.

Capacity building work in Central Asia is now in the hands of local training partners who are supported by the Almaty-based Community Development Center Accord. This summer, a team from Kazakhstan, Tajikistan, and Kyrgyzstan developed new materials, including a book and video with guidelines for workshop activities. Teachers and guidance counselors in the region who work with youth such as Marat in marginal urban schools will now have this as a training tool. An example of what grows out of sharing, exploring, and practicing, this is another welcome contribution to future Street Choices workshops in the former Soviet Union and throughout the world.

David James-Wilson is the director of program development for Street Kids International in Toronto, Canada. Lena Vinogradova is the director of the Community Development Center Accord in Almaty, Kazakhstan and a regional program advisor for SKI in Central Asia.

Human Rights and Harm Reduction
Calling for an Alliance

Photo © 2002 Hans-Jürgen Burkard

by Joanne Csete

Is access to harm reduction services a fundamental human right?

The dilemma of a woman drug user in Central Asia provides one answer. She wants to take advantage of a needle exchange site, but is afraid that if she uses the site, her name will be entered on a government list and she will risk official harassment and perhaps even arbitrary arrest. For her, using needle exchange is as much a struggle for the right to privacy, the right to be free of police violence and other official abuse, and the right not to be arrested or detained arbitrarily as it is a struggle for the right to basic health care and protection against a deadly disease. If she has children, it may also be a battle to protect the rights of her children to be free of stigma and discrimination and not to be institutionalized against her will.

For a young man injecting drugs and living on the streets in an urban center of Eastern Europe, the struggle for clean needles or methadone may also be the struggle not to be harassed by the police, arbitrarily rounded up on the street like a criminal, or put in conditions of detention where needle-sharing and lack of protection from sexual violence make HIV transmission almost inevitable.

Harm reduction in the former Soviet empire would be much easier if governments in the region respected the commitments contained in the human rights treaties they have already ratified, especially the International Covenant on Civil and Political Rights, which guarantees due process and protects all persons from discriminatory or arbitrary arrest or violence. Instead, governments have let the social stigma attached to drug use—and the politics of disdain and neglect that follows stigma—override those commitments.

Whether it be the daily struggles of ordinary people to use harm reduction services with dignity and free of fear, or the lofty sentiments of international treaties, one thing is clear: the provision of harm reduction is a global human rights issue.

The continued, widespread abuse of the human rights of injection drug users (IDUs) is a recipe for a bigger HIV/AIDS epidemic in Eastern Europe and Central Asia. People who face harassment, stigmatization, and official abuse are the least likely to seek information and services related to HIV. Stigmatizing and marginalizing the highest-risk persons with respect to AIDS is a surefire boost for the epidemic as it pushes those most in need of protection and prevention underground. In Africa, AIDS feeds off of the subordinate status of women and girls who cannot negotiate safe sex. In many parts of Asia, it has gained a foothold because of the ostracization or persecution of women in prostitution and men who have sex with men. HIV/AIDS, too, is a global human rights challenge.

Protecting the rights of and reducing discrimination against IDUs, men who have sex with men, and others who have been heavily affected by HIV, is good public health policy and a good human rights priority. But action to

continued on page 10

Kyrgyzstan: Leading the Way on Methadone

by Tynchtykbek Asanov

The first time Kyrgyzstan's health care and law enforcement representatives discussed methadone substitution therapy in the summer of 2000, they were decidedly unenthusiastic. The new idea met with prejudice and stagnant thinking.

So how, only two years later, did Kyrgyzstan become the first country in Central Asia to introduce the practical use of methadone for substitution treatment of opiate addiction?

Unfortunately, this welcome policy change was helped by the revelation in the fall of 2000 of a sharp increase in the number of HIV cases in the Osh region. The increase was especially high among injection drug users (IDUs). For the first time many people were forced to seriously consider HIV/AIDS prevention.

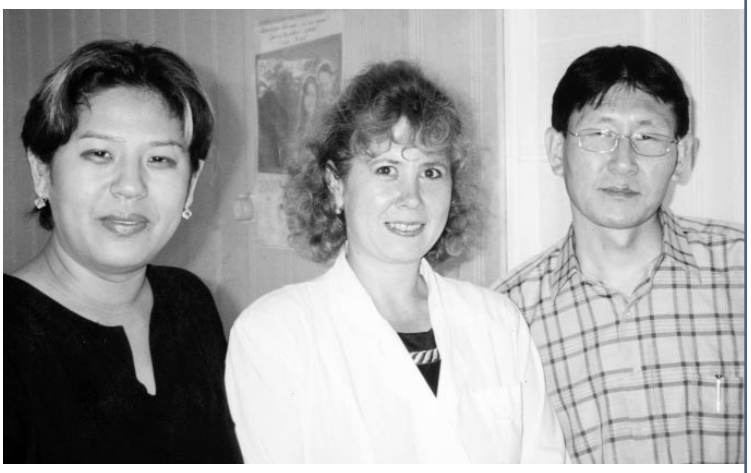
Kyrgyzstan also had favorable drug laws prior to the introduction of methadone treatment. There are no legal barriers to the use of narcotic drugs to treat drug addiction. Buprenorphine, for example, had been used under the name of *norphine* for many years for the detoxification of opiate addicts. Further, methadone was not included on the list of narcotics prohibited from use for medical and scientific purposes.

Implementing methadone therapy in Kyrgyzstan had distinct legal, technical, and practical stages.

During the legal stage, advocates for methadone treatment had to overcome opposition from the government ministries responsible for public order and control of narcotic drugs. We had three private working meetings with them dedicated to the methadone program. We also had three televised public discussions involving doctors, lawyers, and police. And we held briefings for the mass media that provoked many newspaper articles in the months leading up to the launch of the methadone program.

It is too early to speak about conclusive results for Central Asia's first methadone pilot, but the changes so far have been almost entirely positive.

By the summer of 2001 the Soros Foundation–Kyrgyzstan and the Republican Narcology Center had received all the necessary paperwork, clearing the way for an agreement that provided a grant to the center for a pilot methadone therapy project in Bishkek.



Elvira Muratalieva (left) of Soros Foundation Kyrgyzstan with Tynchtykbek Asanov (right) and staff of the Bishkekmethadone program. Photo by Matt Curtis

Once all the legal requirements were cleared, the technical stage began. We made minor repairs to the center, bought essential equipment, and signed an agreement for the delivery of methadone hydrochloride from Slovakia.

In late January 2002, methadone arrived in Bishkek. "This is a historic event," said IHRD's methadone technical advisor Emilis Subata from the Vilnius Substance Abuse Treatment Center in Lithuania. "Methadone has finally appeared in Central Asia."

Implementation of the third, practical stage started in April in Bishkek and Osh when the projects saw their very first clients, who had heard about the project from the media. The majority of later clients came to the projects based on the recommendation of participants.

In a strategic compromise move to appease opponents concerned about the illegal circulation of methadone, the programs have a high threshold for accessibility. Methadone therapy can be provided only at state narcological institutions, and doctors from other agencies or with other specializations do not have the right to prescribe methadone to their patients. Anonymous participation in these programs is prohibited. The methadone solution is given out daily and there is periodic testing of clients for the presence of other narcotic drugs and psychotropic substances. If the consumption of illegal opiates is confirmed the participant can be excluded from the program. We expect these harsh conditions to be softened, however, if the pilot projects prove successful.

Currently there are 72 participants in the two programs—42 in Bishkek and 30 in Osh. It is informative to profile the Bishkek

continued on page 10

Methadone News

In July **Kazakhstan** legalized the use of methadone as a drug replacement therapy, making it the second Central Asian country to do so, and one of an increasing number of former Soviet countries to adopt or consider methadone in the last year. Two pilot programs were approved, and are scheduled to begin operation in late 2002 in Pavlodar and Karaganda with approximately 80 patients.

Ukraine is now looking to oblast narcology centers to pilot methadone replacement therapy after two years of policy work.

Two pilot projects in **Belarus** will likely be funded by UNDP-Belarus and IHRD before the end of 2002.

IHRD will provide technical assistance to a World Bank funded methadone project in **Moldova** later this year.

IHRD and Continuum Health Partners, Inc. are sending top narcologists from **Russia** on a methadone study tour to Paris this fall.

Governments have let the social stigma attached to drug us—and the politics of disdain and neglect that follows stigma—override human rights commitments.

Photo © 2002 Hans-Jürgen Burkard

Human Rights continued from page 8

support such measures remains hard to find in too many countries.

Mainstream human rights organizations have been slow to embrace harm reduction and the cause of reducing HIV/AIDS-related rights abuses. Civil society groups that focus on harm reduction and HIV/AIDS should do what they can to draw human rights groups into their struggle, and human rights groups should realize that IDUs and people affected by HIV/AIDS can help lead the way in human rights battles. Abusive authorities will always go after IDUs and AIDS-affected persons, along with racial and ethnic minorities, because it is easiest to get away with mistreating those in society who are most stigmatized. If abuses can be reduced among these populations, including by their empowerment to speak out and organize on their own behalf, the overall human rights gains will be significant.

Does framing these issues as a human rights struggle really help? HIV/AIDS non-governmental organizations from the North and South have joined in the last two years to form an effective coalition promoting the right of all persons living with AIDS to treatment for their disease. In this period, thanks to long advocacy, the United Nations Commission on Human Rights twice asserted that persons with AIDS have the right to anti-retroviral treatment, once over the abstention of the United States. These resolutions helped create an environment in which African, Asian, and Latin American governments gained confidence to strike deals with manufacturers of cheaper generic drugs and otherwise challenged the multinational pharmaceutical companies that had a lock on many markets.

It is time for national and international human rights groups, including international groups and the growing civil society movement for human rights in the former Soviet states, to challenge repressive drug laws and official practices that violate international human rights standards. It is time for them to join the harm reduction and HIV/AIDS movements in making a well informed and deafening noise about the crime of abusing the human rights of IDUs.

Joanne Csete is the director of the HIV/AIDS and Human Rights Program at Human Rights Watch in New York.

Kyrgyzstan continued from page 9

participants. They range from 20 to 51 years old. One-quarter of them are women. They have been using opiates for an average of 11 years and practically all of them have concomitant disorders such as anxiety and depression. A little more than half are infected with viral hepatitis. At the time they entered the program, almost all of the participants used heroine intravenously (one was shooting up in the muscle tissue as all accessible veins had atrophied or sclerosed). The average dose of heroine during the last month before entering the program was 1.2 grams a day in 2-3 daily injections. Two of the program participants are HIV positive. Nearly 60 percent have prior convictions.

Since the project started, three participants have left. One was convicted for a criminal offence, another was excluded from the program for an attempt to carry out methadone from the office, and the third stopped coming into the program of his own accord.

The somatic health of the participants has improved noticeably. The patients and their relatives report sleep stabilization, restoration, and "mood improvement." Women also report restoration of their menstrual cycles.

While there have been no major changes in the social status of the participants since the projects started, one patient has gotten married, one has returned to his family, and two participants have started working. There has also been a significant improvement in personal relationships, especially with the clients' families.

It is too early to speak about conclusive results, but the changes that have occurred have been almost entirely positive. We plan to conduct a program evaluation next year and present its results to all countries in Central Asia.

Tynchtykbek Asanov is the director of the Republican Narcology Center and chief narcologist at the Ministry of Health in Kyrgyzstan.

Struck by Drugs, HIV, and a Will to Respond

by Muratboki Bekhazarov

Tajikistan near the Afghanistan border, Russian border guards apprehend two young men. A bag of heroin is in the foreground. Photo © 2002 Hans-Jürgen Burkard.

In the last year and a half the number of people infected with HIV in Tajikistan increased eight times more than it did in the last decade. Seventy-three percent are injection drug users (IDUs). As stunning as these figures are, they do not come close to the reality of the HIV epidemic. As in other Central Asian countries, the lack of tests and diagnostic equipment makes epidemiological surveillance of the vulnerable populations almost impossible.

We do know, however, from a joint government-UNAIDS rapid situation assessment of drug use in Dushanbe in 1999, that the spread of HIV is related to injection drug use. An estimated 15-18 thousand people were found to be users of drugs, mainly heroin, of which 4-5 thousand injected. Almost no drug users used condoms.

The assessment also determined that the violent increase in the number of IDUs in the previous few years among 20-35 year olds was related to the economical high from injecting rather than inhaling heroin. Sharing syringes in a group was typical among 93 percent of the IDUs and few drug users disinfected their apparatus.

The rise in drug use can be squarely blamed on the appearance of heroin in the country. Before 1996-1997 there were practically no IDUs. Bordering Afghanistan, China, Uzbekistan, and Kyrgyzstan, Tajikistan has the misfortune of being located on a drug trafficking route. Both the fall of the Soviet Union in 1992 and the civil war in 1993-1994 made it difficult to control the flow of drugs. Further, in the four years after the end of Soviet rule, unemployment increased seven times. Many people looked to drug smuggling and dealing to earn money.

Recognizing the growing HIV problem, the Republican AIDS Center opened two stations for IDUs in Tajikistan's capital, Dushanbe, in November 1999. With support from UNAIDS, the Ministry of Health, and the city government, we provided counseling, disseminated information, distributed condoms, and exchanged needles. The program was well run and only specially trained consultants (a narcologist, a dermatologist-venerealogist, and a psychotherapist), social workers, and volunteers worked in the stations. Everything was anonymous and confidential. Yet during the first six months we reached only 60-70 people.

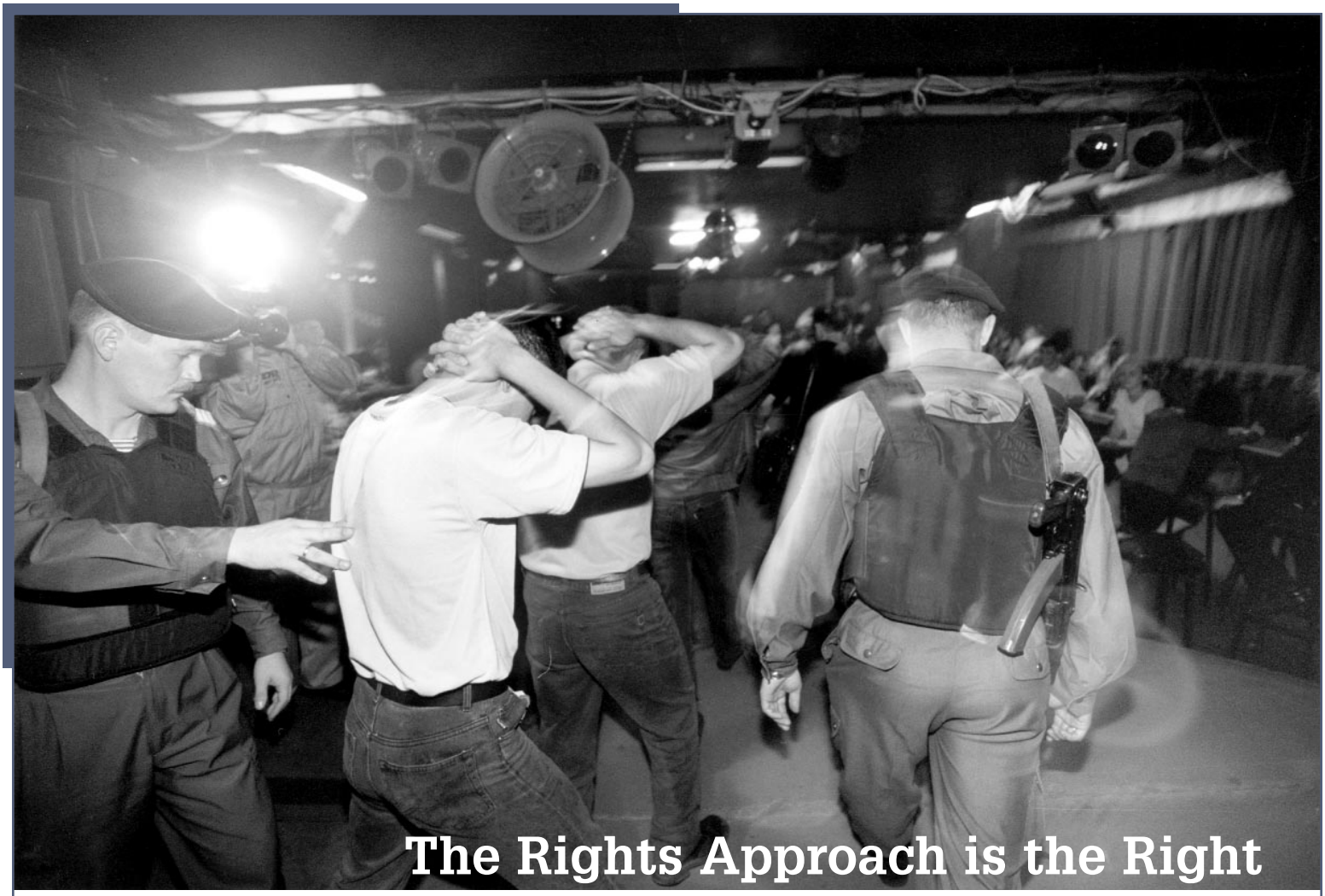
The rise in drug use can be squarely blamed on the appearance of heroin in the country. Before 1996-1997 there were practically no IDUs.

To attract more clients to the projects, the Republican AIDS Center worked with trained volunteers to do outreach and peer education among drug users. It was also necessary to create a more favorable environment for the harm reduction program and stimulate public debate. We held seminars, round table discussions, and press conferences for politicians, law enforcement officials, the mass media, and the general population on HIV prevention among IDUs.

Six new stations were opened in 2000 with financial support from the Open Society Institute in New York. The worsening HIV situation prompted the creation of several more locally funded programs across the country. All told, 15 stations now serve an average of 1,500 drug users daily, approximately 5 percent of the estimated number of IDUs in the country.

Key ministries and departments have already approved a national strategic plan to respond to HIV/AIDS. The plan, developed by the government, nongovernmental organizations, and international experts, highlights HIV prevention among IDUs. The problem is recognized at the highest government levels, including by Tajikistan's vice-prime minister who spoke out about HIV prevention among IDUs at the International AIDS Conference in Barcelona in July. Recognition has been translated into financial support—the government funds eight projects—but the need is far greater than the state's ability to meet it.

Muratboki Bekhazarov is the director of the Republican AIDS Center and National AIDS Coordinator.



The Rights Approach is the Right Approach to Harm Reduction in Central Asia

by Erika Dailey

First, they check through our things and our clothes at the train station and ask rudely, "Where are you hiding the narcotics?"… Last time… they found 50 grams of heroin on someone in our car, so they held the train for four hours. They took all the passengers in that car out to the station building, separated the men and the women and made us all strip naked … It's appropriate that they arrested the guy who had the heroin on him, but why do they humiliate and insult everyone else? Khomid Irodai, in the newspaper *Sadoi Mardum*, Tajikistan, 2000.

Two of the greatest risks to human development in Central Asia are the spread of AIDS and human rights violations. While they appear to be very different phenomena, a careful examination of the human rights environment existing in the region offers clues to both the reasons for the disease's rapid spread and the most effective ways to combat it.

While official prevalence rates are still low relative to population, it is a stark but now indisputable reality that pre-conditions for an AIDS explosion exist for the approximately 55 million residents of the five Central Asian states: Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan, and Uzbekistan. HIV is spreading faster in this region than elsewhere in the world for one reason: drug use. According to UNAIDS data for 2001, injection drug use accounted for 70 percent of HIV transmissions in Kazakhstan. (The rate is 22 percent and 18 percent in Kyrgyzstan and Uzbekistan, respectively, and no data are available for Tajikistan and Turkmenistan.)

Central Asia's geographic situation on the drug trafficking route from Afghanistan—the world's largest producer of opium—to Russia, Ukraine, and points west means that heroin is readily available and inexpensive, in many places cheaper than vodka. A single contaminated syringe becomes more lethal than a knife, potentially killing off tens of people in a day—many more than could be infected through sexual transmission. Until injection drug use is made safe, and other exacerbating factors like sexually transmitted infections are brought under control, the rampant Central Asian drug trade will continue to cause disproportionately high rates of HIV infection.

Against the backdrop of the rise of HIV in Central Asia, the Open Society Institute's Central Eurasia Project (CEP), which has a geographic mandate for Central Asia, has forged a close partnership with IHRD. Together, we have advocated with United Nations and U.S. government agencies, local governments, intergovernmental organizations such as the Organisation for Security and Cooperation in Europe (OSCE), and international donors for human rights protections as a precondition for stemming the HIV epidemic in Central Asia.

Human rights protection as a tool against HIV

Global experience has shown that protection of human rights is one of the most important pre-conditions for effectively combating AIDS. Sponsors of the XIV International Conference on AIDS, held in Barcelona in July, called on affected countries to "generally refrain from using criminal law to deal with conduct that carries the risk of HIV transmission." But in Central Asia, criminal penalties are routinely imposed unduly and without deterring illegal activities, such as drug trafficking, which appears to be on the rise.

Arguably the most fundamental category of human rights relevant to the discussion of AIDS prevention and treatment in Central Asia is the right to adequate health care. The International Covenant on Economic, Social and Cultural Rights enshrines "the right of everyone to enjoyment of the highest attainable standard of physical and mental health." (Article 12.1) Specifically, it obliges States Parties to the Covenant to take steps, among others, to achieve "[t]he prevention, treatment and control of epidemic… diseases." (12.2.c)

Civil rights protections, such as freedom of information, freedom from discrimination, and due process guarantees, are equally fundamental to access to AIDS prevention and treatment. State censorship muffles or blocks information about the epidemic to varying degrees in the region. An extreme case is Turkmenistan. There, strict one-man rule has kept the country in near total information black-out since the early 1990s. As a result, official prevalence data are presumed to minimize social problems and are believed to be serious underestimates. According to a World Bank study, for example, U.N. agencies estimate that there are over 50,000 drug users in the country, which has an adult population of approximately 2.5 million—over eight times higher than the state estimate.

International human rights law prohibits all forms of discrimination. However, discrimination against drug users in Central Asia is widespread and unchecked. It can also be deadly. Part of state prejudice against drug users is a deep-rooted legacy from the Soviet period. The Soviet state labeled drug users "parasites," imposed criminal penalties on drug users, and forced health professionals to turn in drug users to law enforcement authorities or face reprisals.

Existing prejudices against drug users are reinforced today by the current hostile criminal justice environment. Human Rights Watch has documented a well-established pattern of police planting heroin on political and religious dissidents in Uzbekistan to fabricate criminal charges against them and discredit them. Drug-related offenses are even punishable by the death penalty in Tajikistan.

IHRD has also reported several known incidents of police harassment of drug users. In Osh, Kyrgyzstan, police raided a needle exchange center in an apparent attempt to more easily meet their quota of arrests. The result was to drive users away from the centers, where they could safely dispose used needles and receive clean ones, and back into private homes and alleyways where the risk of infection is much higher.

Police and border guards in Central Asia are also known to violate fundamental due process norms in drug-related searches. Travelers at border crossings and checkpoints in Tajikistan, for example, report routinely undergoing searches without probable cause. For women from Tajikistan, the strip searches and vaginal searches are particularly traumatic, according to Martina Vandenberg of Human Rights Watch, because sexual violence was widespread during the civil war that devastated Tajikistan in the 1990s.

Photos: above and preceding page © 2002 Hans-Jürgen Burkard

Central Asian governments need to arm themselves with not only clean syringes but an unshakeable commitment to human rights protections to avert an outbreak of AIDS.

Fighting back

Virtually none of the governments in Central Asia currently has the funds, medications, or expertise to diagnose and treat those who will fall ill to HIV and AIDS and many other public health problems. The full-blown AIDS epidemic is a disaster they cannot afford to have.

It is axiomatic that money spent on prevention will be much more effective than money spent on treatment. Local governments and international donors can avert some of the social, economic and human devastation the disease leaves in its wake by making HIV prevention a top national priority. Some of this will require funds; donors can help. But much more requires no money at all—simply state protection of human rights, such as freedom of information and freedom from discrimination.

A centerpiece of the CEP and IHRD's joint advocacy is sponsorship of an international conference, "Health Security in Central Asia: Drug Use, HIV and AIDS," October 14-16, 2002, in Dushanbe, Tajikistan, co-sponsored also by the Netherlands Ministry of Foreign Affairs. The purpose of the conference is to promote specific strategies for the harm reduction approach to combating AIDS and to improve protection of relevant human rights in the region.

But this is only one small step along a very long road. Central Asian governments need to arm themselves with not only clean syringes but an unshakeable, demonstrable, and sustained commitment to human rights protections if the burgeoning outbreak in Central Asia is to be made anything less than catastrophic.

Erika Dailey is a program officer at the Open Society Institute's Central Eurasia Project.

A Brighter Future for Sex Workers

Iskandar Ismailov of OSI-Uzbekistan (left) with Sabo staff and volunteers. Photo by Sue Simon

by Tadjikhon Saidikramova

Some commercial sex workers (CSWs) in Uzbekistan are as young as 17 years old, although most are in their early 20s, and stay in the profession for an average of two years. Few are married and 20 percent have a child. Thirty percent inject drugs. But their biggest risk of HIV is from unprotected sex: At the client's request, every third CSW does not use a condom.

HIV is spreading in Uzbekistan. As of July 2002, 1,393 HIV cases were officially registered in the country—1,230 men and 169 women. Over 80 percent of the infected are injection drug users (IDUs). Sexual transmission is not prevalent but government and United Nations experts predict that the number of cases will increase in the coming years. This trend is accompanied by the increasing involvement of drug users in commercial sex work.

The center Sabo opened in Tashkent four years ago to help socially vulnerable women create a brighter future for themselves. In ancient Uzbek, *sabo* means "morning freshness" and calls to mind a bright future.

The center started with very small steps. Doctors and teachers experienced in social and educational work were among Sabo's founders. The center had no financial or material resources, but we had extensive life experience and a desire to change society for the better. At first staff worked with students, housewives, girls, and those entering marriage. Soon the center's HIV/AIDS program began to focus on female CSWs because they are among the most at-risk and marginalized groups in Uzbek society.

The sex workers that come to Sabo know about safer sex, contraceptives, and the prevention of HIV and sexually transmitted infections.

Uzbek laws do not define prostitution, and liability for engaging in commercial sex work is not clearly established. But public opinion *is* clearly established, condemning women for frivolity with men and blaming them for prostitution. Their stigmatization forces them into secrecy making them difficult to reach and mistrustful even of the people who try to help them.

In this climate, we understood that women would come only if they trusted us. The negative public attitude makes CSWs wary of openly discussing their problems. But many of them are unhappy and need support. They need medical, psychological, and legal aid. Sabo accepts CSWs for who they are. Our goal is solely to lower the behavioral risks. The first women who visited Sabo benefited from our unequivocal support and helped bring more CSWs to HIV/AIDS prevention trainings.

Last year, the center conducted a six-month needs assessment project to learn more about our clients. The project identified the need for confidential services from a gynecologist, dermatologist-venerologist, psychologist, lawyer, and immunologist, which the center now provides for free. The center also runs a hotline and distributes informational materials, syringes, and condoms. Some CSWs train to become volunteers themselves. And the center provides over 90 CSWs with information about safety and legal rights.

The CSWs that come to Sabo know about safer sex, contraceptives, and the prevention of HIV and sexually transmitted infections. In four years Sabo has grown into a busy center with a professional staff and 25 volunteers. HIV-positive people have started to frequent the center and Sabo is looking into ways of formally assisting this group as well.

The lack of knowledge about HIV and its prevention in this society, where the topic is considered indecent and where conforming to behavioral norms is of utmost importance, is worrisome. Overcoming ignorance and prejudice requires initiating discussions in the mass media about public and official attitudes towards HIV/AIDS. For those who are healthy, for those who might be infected, and for those who are already ill, it is not just an issue of physical health. It reflects on our spiritual health.

Tadjikhon Saidikramova is the chair of the coordination council for Sabo.

HIV and AIDS Treatment in Central Asia

by Jay Dobkin

Central Asia has all of the ingredients for a major HIV/AIDS epidemic: a large population of young, sexually active injection drug users (IDUs), epidemic levels of sexually transmitted infections (STIs), and an absence of drug treatment and HIV prevention programs. But the number of cases is still small and a large outbreak is not inevitable.

Official statistics indicated virtually no HIV cases in Central Asia before 1997 when an outbreak of several hundred HIV cases was reported in the city of Temirtau, Kazakhstan, and the surrounding area. In the last two years several other Kazakhstan cities have detected clusters of cases and outbreaks have been noted in Kyrgystan, Uzbekistan, and Tajikistan.

The questions of how and why the HIV outbreak occurred in Temirtau have been endlessly discussed and cannot be answered definitively but the region's recent history seems to give a clue. During Soviet times the great coal deposits in the area were exploited and the region became a major mining and steel production center. Temirtau prospered as one of the largest steel centers until the Soviet Union broke up in the early 1990s and the inefficient mill struggled through several management changes before closing entirely. According to local observers, the social fabric in this city of 125,000 came apart with explosive increases in alcoholism and drug use, even by pre-teenaged children.

Among several probable factors in the Temirtau HIV outbreak are the rapid growth of drug use and the large number of young users. The role of psychological factors such as the hopelessness triggered by economic upheaval leading to risky patterns of drug use and sexual activity is more speculative.

Since HIV infection proceeds silently for several years before the clinical illnesses known as AIDS begin to appear, there is a lag time before the impact of new epidemics is felt. The new HIV infections that have occurred in the last few years will begin to translate into illness and death over the next five to 10 years. This time can be used to delay or prevent much of the morbidity and mortality of HIV.

However, little treatment for HIV is available in Central Asia and this is not likely to change any time soon. The region is wracked by political and economic turmoil and other, more immediate, health crises. There is little time or attention for the HIV epidemic, which is in its early stages and has not reached the critical dimensions of sub-Saharan Africa. Further, the primary affected group—drug users and their partners—are severely marginalized and often viewed as expendable.

The AIDS centers in Central Asia that do try to meet these challenges have found that comprehensive care for HIV infected patients has four components: general health promotion; substance abuse treatment; opportunistic infection prevention; and anti-retroviral therapy.

Since most patients are young and free of chronic diseases, little general health care is needed unless STIs or complications of drug use are present. Substance abuse treatment, however, may be the most critical step in successfully dealing with HIV infection because it often requires complex regimens with daily medications.

Most of the severe infections that complicate the advanced stages of HIV disease (so-called "opportunistic infections") can be prevented

continued on page 16

continued from page 15

or delayed with simple oral medication. A single daily dose of the antibiotic trimethoprim/sulfamethoxazole, for example, is highly effective in preventing two of the most common complications: pneumonia and toxoplasmosis. The medication is inexpensive (less than one U.S. dollar a month in some former Soviet countries.)

The challenge of tuberculosis (TB) deserves particular attention in the discussion of opportunistic infections. Although HIV infection is not needed for TB to flourish, there is a potent interaction between these two infections. Individuals with HIV and latent TB infection are much more likely to have a reactivation of TB than those with TB alone. And HIV infected persons are more susceptible to primary infection with TB. These trends become more pronounced as the degree of immunodeficiency increases over time. Thus, the epidemic potential for the spread of TB among HIV positive individuals in congregate settings like AIDS wards and prisons is great. Since TB is one of the world's most common infections and disproportionately affects impoverished people and countries it is likely to be the greatest cause of illness and death associated with HIV in many areas.

New HIV infections will begin to translate into illness and death over the next five to 10 years.

The Central Asian countries have higher rates of TB than Europe, North America, or Russia. As the AIDS epidemic takes hold, TB will become an even more formidable problem. Treatment and prevention of TB in HIV infected persons are potentially effective but there are obstacles. TB patients must adhere to and complete at least six to nine months of treatment. Interruption of this course compromises treatment response and also raises the chances that the infection will become drug resistant. Spectacular mortality rates have been noted in outbreaks of multi-drug resistant TB in prisons and AIDS facilities around the world.

AIDS care programs can help control TB by ensuring follow up and completion of therapy. Although the concept of directly observed therapy for TB is generally accepted in Central Asia the patterns of care still heavily emphasize hospital based treatment. After being treated for several months in a TB hospital patients often do not complete the full curative regimen because there is little access to outside treatment. AIDS treatment centers could help by ensuring that HIV-TB patients complete their therapy. However, the current, rigidly vertical structure of TB care in Central Asian countries makes such an approach problematic.

Understandably, most discussions about access to HIV care focus on anti-retroviral treatment because this intervention has transformed AIDS from an inevitable killer to a manageable chronic disease in the West. In other parts of the world, there are increasing prospects for patients to have access to anti-HIV treatment through the Global Fund to Fight AIDS, Tuberculosis and Malaria. However, drug costs remain an enormous barrier to HIV therapy since even the cheapest generic versions are still beyond the means of most individuals.

Policy makers, AIDS caregivers, and even harm reduction advocates tend to exaggerate the potential difficulties of anti-HIV therapy among previous or current drug users. Some national AIDS programs exclude active drug users from HIV therapy as a policy and it is often assumed that any drug use history means current use is likely. Just as bad, several advocates for drug users give users the impression that the toxicity of the treatment and variable degree of success makes it less desirable than it might seem.

The plain fact is that uninterrupted access and adherence to an appropriate HIV treatment regimen is the only requirement for success. Active substance abuse may make this difficult for some, but not all, patients. Ancillary efforts such as substance abuse treatment, counseling, and treatment supervision all enhance the effectiveness of HIV treatment in this population.

The urgency of anti-HIV therapy in areas like Central Asia may be hard to grasp especially compared to much larger, more advanced epidemics. But the potential for HIV treatment to limit the spread of the epidemic is real—by decreasing the infectivity of those who are treated and by drawing many of those who fear it into preventative care. It is also urgent that the policy makers and caregivers begin to confront the nuances of working with drug users rather than excluding them as a group.

Jay Dobkin is the director of the AIDS Program at Columbia-Presbyterian Medical Center in New York.

Prison News

In Lithuania, the results of HIV testing at the Alytus prison by the Lithuanian AIDS Center that found 222 of 1,900 inmates HIV infected prompted the resignation of the head of the prison department in June. Shortly after, about 7,000 inmates joined a hunger strike. Their demands included treatment for HIV detainees, cessation of the transfer of inmates from Alytus, and better conditions in general.

In Russia, one-sixth of the registered cases of HIV are in jail and contributing to the fastest growing rate of HIV in the world, according to a report by UNAIDS and the World Health Organization. Strict drug laws are increasing the prison population and, once there, injection drug use and needle sharing is prevalent. Health services are inadequate: condoms and methadone are not allowed, HIV testing is unreliable and inconsistent, and many doctors oppose harm reduction.

A report investigating overdose in CEE/fSU suggested that fear of prison guards leads to overdose. If a group is sharing a syringe with enough drugs for everyone, whoever has the syringe in hand will inject the entire amount when a guard approaches. The report was commissioned by IHRD in 2001.

The 6th European Conference on Drug and HIV/AIDS Services in Prison will be held in Vienna October 10-12, 2002 to assist the development of effective drug and health services in European prisons. www.cranstoun.org.

Preventing HIV Before It Starts

by Aimuhammedova Nurnabat

In a striking example of foresight, Turkmenistan has started an HIV prevention program in prisons. Official data indicate no cases of HIV in the prison system and HIV prevalence in the country is thought to be low. Yet the potential for a large epidemic is reflected in the high rates of drug use and sexually transmitted infections.

The HIV/AIDS/Drug Abuse Prevention in Prisons project, run by the nongovernmental organization Force for Change has reached over 2,000 inmates since 2000. The project teaches prisoners how to protect themselves from HIV and practice safer sex by motivating clients to change unsafe behavior.

Collaborating with the National AIDS Center and the Ministry of Internal Affairs, Force for Change identifies leaders among the inmates and works with prison personnel to gain their cooperation. The leaders are trained to carry out peer support education. Special information materials for the project have been developed, tested, and produced. Such information and counseling have proven particularly successful in gaining clients' trust. Methadone replacement therapy is illegal and the possibilities for needle and syringe exchange are being studied by Force for Change. Yet some harm reduction practices such as disinfectants in prison dormitories and condom distribution are used in the project.

Prison staff being trained in HIV prevention in Turkmenistan. Photo © 2002 Force for Change

Force for Change chose to start the project, which is supported by IHRD, in the Akhalsky prison system since its three penitentiaries are located within one city. The work will continue here while we expand the project to other prisons in the country.

Aimuhammedova Nurnabat is director of the NGO Force for Change in Ashgabat, Turkmenistan.

Given a Chance, Police Favor Harm Reduction

by Toulesh Ergaliev

Heroin was seized for the first time in Uralsk, the regional center for western Kazakhstan close to Russia's border, in 1998. Since then, law enforcement agents have been regularly detaining drug users and heroin dealers. Drugs come into the city through Russia from the Chechen Republic and from the southern parts of Kazakhstan, where it is trafficked from Tajikistan and Kyrgyzstan.

By July 2002 the local narcological hospital had registered 1,211 "drug addicts." The city has registered 112 people living with HIV. In response to the HIV epidemic, IHRD technical advisor Nurlan Disonov set up a nongovernmental organization needle and syringe exchange called *Movement*. There is some uncertainty in the public mind in Uralsk about the legality of needle exchange. It is widely believed that drug users are criminals and a threat to public order because they use drugs in the backyards and doorways of houses and sometimes commit crimes.

On an IHRD study tour for policemen last year, I visited a harm reduction project in Poland. The project was interesting and novel to me, especially the way it gave hope and optimism to drug addicts. What I saw in Poland persuaded me that the state is not the only entity that can deal with the drug problem.

Many drug users are afraid of the police and law enforcement officials because current legislation mandates that we charge them with illicit drug trafficking. And most policemen are in favor of isolating and incarcerating drug users. If they knew more about harm reduction they would understand that it enables drug users to stop violating the law and return to society as useful people.

Toulesh Ergaliev is lieutenant colonel at the Department of Drug Control, Interior Affairs, Region of Western Kazakhstan.

NewsBriefs

Gay Men's Health Crisis (GMHC) and IHRD have announced an HIV Advocacy Fellowship program that will bring advocates from Eastern Europe and Central Asia to GMHC's New York headquarters for an intensive six-week program in late 2002. Fellows will learn the skills needed to change the HIV/AIDS policies of governments, employers, and private institutions, such as pharmaceutical companies, so that they best serve the needs of people living with HIV.

The Reference Group on HIV/AIDS Prevention and Care Among Injecting Drug Users will advise the UNAIDS secretariat and its six U.N. co-sponsors on effective HIV/AIDS prevention and care among IDUs. The group, established and supported by UNDCP, WHO, and UNAIDS, invited Kasia Malinowska-Sempruch to participate and held its first meeting in Vienna in July.

Pre- and post-test HIV counseling is the subject of the newest IHRD training, which covers counseling, care, and support, discussion of case studies, and working out the methods of providing assistance. The first training session was held in Poland in September and attended by 20 IHRD grantees.

IHRD's technical advisors met in July in St. Petersburg to discuss key areas of IHRD work: the shift to policy work; the role of harm reduction projects in local and regional advocacy and policy efforts; data collection and monitoring; substitution treatment; care and support for HIV infected IDUs; and the role of TAs in IHRD's long term strategy development.

IHRD's advisory group met in June in New York to discuss IHRD's future development, including the exploration of policy development in sister countries such as Iran and China.

The South Eastern Europe (SEE) Conference on HIV/AIDS met in Romania in June to discuss implementing the Global Declaration of Commitment on HIV/AIDS. Conference members agreed to implement the goals of the declaration and to scale up national responses to HIV/AIDS. Monica Ciupagea made a presentation on IHRD's work with IDUs in SEE.

Concern over Iran's estimated 1.5 million opium addicts and .5 million heroin users prompted Iran to invite Bob Newman of the U.S., Marek Beniowski of Poland, and Alex Wodak of Australia to run a workshop for over 100 colleagues from the private sector, academia, and government ministries. The three-day intensive discussion in June focused on how addiction treatment should be introduced in Iran. "The Iranians are clearly committed to a major initiative aimed not at creating a cute little pilot but addressing the problem on a meaningful scale," said Newman. "I have never before encountered such unequivocal dedication to provide help for those in need."

Mandatory HIV testing of high risk groups has been abolished in Kazakhstan, according to the Kazakh newspaper *Novoye Pokoleniye*. Only blood donors will undergo obligatory examination in a country which had in May this year 2,780 people registered with HIV. The new rules were recommended by Western human rights organizations which criticized the mandatory testing as a violation of human rights.

HIV prevention measures have successfully reduced the growth of HIV in Latvia, said the Welfare Ministry in July. The Baltic News Service reports that eight new needle and syringe exchange points will be set up throughout the country.

Two-thirds of the military conscripts in Russia's Chelyabinsk region were found unfit for service in the spring of 2002, largely for health reasons. According to a report by ITAR-TASS, 215 young men were HIV infected and 217 were "drug addicts." An additional 6,000 men of call-up age in the region have criminal records and cannot be drafted.

The HIV/AIDS epidemic is a U.S. foreign policy imperative, declared the U.S. Department of International Health and Science in August. A representative of the department also noted the urgency of preventive measures in Russia, China, and India, according to *AIDS Policy and Law*.

John Ranard, a social documentary photographer who has provided stunning photographs of IDUs to OSI/IHRD now has a website: www.johnranard.com.

XIV International AIDS Conference

IHRD TA Marek Beniowski at the satellite.

Central and Eastern Europe and the former Soviet Union made an impression at the International AIDS Conference held this year in Barcelona in July. A satellite meeting run by the Eastern European Harm Reduction Network was the first event ever at the conference to focus on the region. On the strength of his appearance at the satellite, Stas, a Russian living with HIV, was invited onto the stage at the closing plenary with Nelson Mandela and Bill Clinton. Kasia Malinowska-Sempruch gave a plenary speech to thousands of people that was widely quoted in the international press. It was the first time at the conference's plenary that a speech focused on the region or on drug use issues.

Marek Kotanski

1942-2002

Marek Kotanski (right) with MONAR outreach worker Dariusz Denis talking with needle exchange clients in Planta Park, Krakow. Photo © 2002 MONAR

For 35 years Marek Kotanski worked for the homeless, sick, and people addicted to drugs. An innovative, tireless problem solver, he founded 110 homes all over Poland and abroad. Many civil society organizations and foundations have their roots in the MONAR Association, the comprehensive system of rehabilitation and prevention of drug addiction that he set up in 1981. MONAR has founded several rehabilitation centers in Russia and Ukraine and served as a model for organizations in Central and Eastern Europe and Asia. Marek Kotanski was nominated this year for the U.N. Vienna Civil Society Award in recognition of his outstanding contribution to counteracting drug abuse, crime, and terrorism.

A letter from all the people of MONAR

With pain in our hearts and utter sadness we wish to inform you that Marek Kotanski passed away as a result of injuries suffered in a car accident on August 19. He was returning from a meeting in one of his houses for homeless people.

Thousands of people in Poland and many countries of the world—the addicted, sick, lonely, homeless, youth, elderly, parents, and teachers—are in profound mourning. Marek was not only the founder of the MONAR Association and its only leader, full of incredible charisma and stamina. He was also fully devoted to others. His motto was "Give yourself to others." He always found time for those in need. One could always count on him. Everybody he met regarded him as a genuine friend.

Marek created MONAR, the largest organization in this part of Europe for the prevention and treatment of addictions. He was always searching for new solutions to social problems. Nobody could keep up with his ideas. A visionary and an idealist. A keen psychologist-therapist and unconventional tutor. His intuition and courage in the search for new, more effective forms of help for people in need often became a challenge to others. His actions, often controversial, would ultimately turn out to be innovative and ahead of their time. Lack of funds could never stop his new initiatives. As a member of official committees and bodies he always spoke the truth openly. He broke stereotypes and provocatively defended the dignity and rights of women and men hurt by destiny and thrown to the social margins.

He used to warn all of us to beware of commercialization and the loss of spirituality. He taught us that it is necessary to *be*, not to *have*. He believed that one could "see only with the heart." He inspired millions of people with his ideas. He always maintained personal relations with all of the employees of MONAR. He loved discussions with friends, heated arguments, and father's lessons. He often asked us: "Do you love me?" We do love...you don't even know how much we do, Marek!

May we have the strength and endurance to continue his deeds. Marek will stay in our hearts forever.

He defended the dignity and rights of women and men hurt by destiny and thrown to the social margins.

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Upcoming Events

November 22-24	November 27-29	December 1-4	December 8-11	April 6-10, 2003
Canadian Harm Reduction Conference	Search for Quality in School Based Drug Prevention	4th National Harm Reduction Conference	North American AIDS Treatment Action Forum	14th International Conference on the Reduction of Drug Related Harm
Toronto, Canada	*Hamburg, Germany*	*Seattle, Washington, USA*	*New Orleans, Louisiana, USA*	*Chiangmai, Thailand*
www.harmreduction2002.ca	**www.school-and-drugs.org**	**www.harmreduction.org**	**www.nmac.org**	**www.ihrc2003.net**